

Exploration of joint working practices on anti-social behaviour between criminal justice, mental health and social care agencies

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Exploration of joint working practices on anti-social behaviour between criminal justice, mental health and social care agencies: a qualitative study

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Abstract

Although the police play an important role for people with mental ill health in the community, little is known about joint working practices between mental health, social care and police services. There is potential for tensions and negative outcomes for people with mental ill health, in particular when the focus is on behaviours that could be interpreted as anti-social. This study explores perceptions about joint working between mental health, social care and police services with regard to anti-social behaviour. We conducted a multi-method sequential qualitative study in the UK collecting data between April 2014 and August 2016. Data was collected from two study sites: 60 narrative police logs of routinely gathered information, and semi-structured interviews and focus groups with professionals from a range of statutory and third sector organisations (N = 55). Data sets were analysed individually, using thematic iterative coding before integrating the findings. We also looked at sequencing and turning points in the police logs. Findings mapped on a continuum of joint working practices, with examples more likely to be away from the policy ideal of partnership working as being central to mainstream activities. Joint working was driven by legal obligations and concerns about risk rather than a focus on the needs of a person with mental ill health. This was complicated by different perceptions of the police role in mental health. Adding anti-social behaviour to this mix intensified challenges as conceptualisation of the nature of the problem and agreeing on best practice and care is open to interpretations and judgements. Of concern is an evident lack of awareness of these issues. There is a need to reflect on joint working practices, including processes and goals, keeping in mind the health and welfare needs of people with mental ill health.

Key words (up to 6): Mental health, police, anti-social behaviour, joint working, partnership working, mental health service provision

What is known about this topic

- The needs of people with mental ill health who experience complex issues such as substance use cannot be addressed by single organisations
- Anti-social behaviour can be symptomatic of mental ill health but people with mental health problems are more likely to be victimised

What this paper adds

- Describes levels of joint working in terms of a continuum
- Documents drivers for and foundations of joint working for people with mental ill health whose behaviour may be experienced as problematic by their community and/or who are victimised by others
- Highlights the need for organisations to reflect on their joint working practices for people with mental ill health whose complex needs touch on the remit of several organisations.

Introduction

It is increasingly recognised that the police are important partners in providing services for people with mental ill health in the community. However, inter-organisational partnership working is under-developed and poorly understood (Carpenter, Gassner & Thompson, 2016; Wood & Watson, 2016). About one-third of people encountering the police forces in England and Wales have a mental health problem (HMIC, 2015). In cases involving unusual or anti-social behaviour estimates are about 60% or more, particularly when substance use is involved (Paterson & MacVean, 2007). There is a lack of UK and European data compared with the United States, but a recent systematic review found that about one in four people with mental ill health have been arrested at some point (Livingston, 2016). Explanations for the rise in police involvement point to the shift from institutional to community care (McLean & Marshal, 2010).

Although the importance of partnership working for people with mental ill health has been a theme of national and international policy for many years (European Commission 2004; Gilbert *et al.*, 2014), the role of the police has been acknowledged only more recently in policy and guidance, such as the mental health strategies in England and Wales (HM Government, 2011; Welsh Government, 2012). People who are concerned about an individual’s disruptive or distressed behaviour tend to call the police. Crucially, the police are an important partner when people are detained under the Mental Health Act (Bather, Fitzpatrick & Rutherford, 2008).

What do we mean by Joint Working?

There is debate over definitions of partnership and joint working, as well as whether partnership working is necessarily a good thing (Dickinson & Glasby, 2010). Nonetheless, compelling arguments for partnership working have been made (Rummery, 2009). We adopted Carnwell and Carson’s definition (2009) of partnership as “a shared commitment,

where all partners have a right and an obligation to participate and will be affected equally by the benefits and disadvantages arising from the partnership” (p.7). Joint working is intrinsic to partnerships, as they are formed with a common goal or vision in mind and require joint working to achieve this. Hudson and colleagues (1997) suggested a continuum of joint working ranging from isolation (no joint activity or communication) to integration (organisations have no separate identities). Stages in between are encounters (ad hoc contacts with divergent organisational goals and stereotyping attitudes), communication (joint working with information sharing for individuals whose needs cross boundaries and some joint training), and collaboration (joint working central to activities, trust and respect in partners, and highly connected networks).

Joint Working in the Context of Anti-Social Behaviour

Research has highlighted gaps in communication and processes between police forces and health and social care services (Bradley, 2009; Independent Commission on Mental Health and Policing, 2013; Rutherford, 2010). Tensions over the role that the police play in mental health care carry over into interpretations of police roles in partnership working.

Anti-social behaviour creates a number of challenges but is often overlooked. There are conflicting policy agendas between anti-social behaviour and mental health community care (Rutherford, 2010). The meaning of anti-social behaviour in relation to mental health is debated, partly because it is open to interpretation but also bound by legislation. The Anti-Social Behaviour Crime and Policing Act (2014) defines it as: “conduct that has caused, or is likely to cause, harassment, alarm or distress to any person, or conduct capable of causing housing-related nuisance or annoyance to any person”. Such behaviour can be a sign of mental health problems and a number of sources point to potentially serious consequences such as criminalisation or homelessness (Manders, 2009; Rutherford, 2010). Repeated incidents of anti-social behaviour are of particular concern, as their impact is cumulative

(Donoghue, 2013). Furthermore, people with mental ill health are more likely to be victims of crime and harassment (Koskela, Pettitt & Drennan, 2015).

There is a particular gap in knowledge about the role of judgement and interpretation concerning anti-social behaviour in partnership working between health and social care organisations and the police forces. This study explores the relationships and perceptions of joint working practices between mental health services, social care services, third sector organisations¹ and police forces with regard to anti-social behaviour.

Methods

Design

This is a multi-method sequential qualitative study (Morse, 2003) conducted over two years in two contrasting sites in Wales, UK. Force A serves an urban area with a low level of anti-social behaviour by regional and national standards (HMICFRS, 2012). Force B serves a rural area with a high level of anti-social behaviour (ibid). This paper presents findings from routinely collected police data on anti-social behaviour and adults with mental-ill health (excluding dementia), together with interviews and focus groups with professionals (see Table 1). The findings are part of a larger funded project. The project was guided by a Project Reference group, including representatives from statutory and third sector organisations and service user and carer representatives. The research received ethical approval from the Wales Research Ethics Committee 7.

Table 1: *about here*

Phase 1: Police Data

¹ This is an umbrella term that covers a range of organisations with different structures and goals including Charities, Community Organisations and Social Co-Operatives. Organisations tend to be independent, non-profit and value-driven but may be commissioned to deliver public services (Corry, 2010).

Information on anti-social behaviour is logged in real time in narrative form and includes details of incidents such as suicide attempts, disturbances or criminal behaviour. Entries record the attending officer's perception of the situation. If it is judged that a mental health issue was relevant to a call-out, this is tagged on the database. As the information is confidential, it was extracted and anonymised by a police employee.

Cases were selected through criteria outlined in Table 1. The two forces record information differently. Since August 2011, Force A has had a specific anti-social behaviour database index by person (person record), rather than location or incident. 222 person records were available on the database. The Force B's Record Management System logs information by incident, but incidents can be linked back to a person. 6,298 anti-social behaviour incidents were recorded within the research timeframe. Anti-social behaviour incidents were searched for and linked to a person to determine repeated anti-social behaviour.

Once the selection criteria had been applied by a police employee in each site, the total number of relevant cases in each site was divided by 30, and the result used to select the sample. For example, if the pool of relevant cases was 60, every 2nd case was selected to provide a sample of 30 for a study site.

There is no national definition of repeat victim or perpetrator of anti-social behaviour (HMIC, 2012). Force A's definition was three calls in six months and Force B's was three calls in 12 months irrespective of who made the call (included concerned neighbours and members of the public). Case details referred to repeated calls over weeks and/or months. Some of the cases we analysed had been closed, others were on-going. Examples of closed cases include re-housing a person who is targeted and/or is perceived as disruptive by others.

Out of the 60 cases, five had no fixed address, 48 lived in social housing, four rented from private landlords, and just three were homeowners. There were 35 women and 25 men with age ranging from 18 to 70 years old. Box 1 illustrates some common themes.

Box 1: *about here*

Phase 2: Individual Interviews and Focus Groups

Organisations were selected with input from the Project Reference Group. The purposive sampling frame included professional groups delivering mental health care or policing in the two study areas. Potential participants were approached through chief executives/directors who passed on a study information leaflet on behalf of the research team. The leaflet made it clear that participation was voluntary and that no information about individual participation and contributions would be shared with chief executives/directors. Staff who wished to participate returned a consent form to the research team directly and interviews were arranged. Feedback suggested that staff felt free to make an independent decision about participation. In addition to individual interviews, there were two focus groups (one with police officers and one with Community Mental Health Team members). We talked to 55 professionals (39 participated in interviews and 16 in focus groups) (see Table 2 for more detail). The interactions lasted on average 80 minutes and were audio recorded with written consent (except one focus groups and one interview where detailed notes were taken). We used a topic guide, and areas of interest included: participants’ roles and responsibilities towards people with mental health problems; challenges when working with people with mental health problems; perceived links between anti-social behaviour and mental health; local arrangements for providing and co-ordinating support; and what helps and hinders joint working.

Table 2: *about here*

Data Analysis

We were interested in participants' perception of joint working practices and barriers and facilitators within organisations. The research was grounded in critical realism, which recognises that there is a real world we interact with and interpret (Sayer, 2000). Critical realism proposes that by considering the social and physical context and investigating processes, explanations can be arrived at (Maxwell, 2012). Using a qualitative multi-method approach allowed us to examine social experience and lived realities more fully by exploring organisational practices and relationships and individual interpretations and experiences (Mason, 2006).

Recordings were transcribed without individual identifying information and labels assigned to be able to link quotes to individual participants: we used *ASB* as the abbreviation for anti-social behaviour, *I* for interview and *FG* for focus group. Transcripts, anti-social behaviour cases and notes were imported into NVivo 10. This qualitative software analysis package allowed us to organise and code data, write memos and conduct searches in a shared electronic environment.

We coded for both deductive a priori constructs based on the continuum of collaboration proposed by Hudson and colleagues (1997), and emergent themes following a thematic approach (Bazeley, 2013). Data were analysed individually, using thematic iterative coding before integrating the findings. A priori sub-themes were: encounter, communication and collaboration (see Table 3). We found no evidence of isolation or integration, the two extremes on the continuum of collaborative working (Hudson *et. al*, 1997).

In addition to a priori codes, the research team developed a broad descriptive coding scheme based on joint reading and coding of the first six police cases in Phase 1. Cases notes were then coded using the agreed and defined codes. We also produced chronological case summaries and looked at sequencing and consequences within narratives whilst keeping in mind that the data was produced for policing purposes (Riessman, 2008).

This early stage of the analysis developed scenarios to illustrate typical features (Miles, Huberman & Saldana, 2014) and initial findings that informed the generation of the topic guide for the second phase (Greene, 1998). We hoped to extract a range of information about partnership working from the cases such as number of contacts between agencies and outcomes of each interaction. However, the data quality, together with confidentiality and anonymity issues, made this impossible.

In discussion, we agreed codes and definitions for data from the second Phase. This included previous codes and some new codes. Finally, we focused on integrating the data by identifying key themes and tracing them across the datasets. According to Moran-Ellis and colleagues (2006) ‘*following a thread*’ is an iterative process aiming to interweave the findings (p. 54). Our focus was on characteristics of collaboration, and facilitators and barriers. Further selective iterative coding concentrated on developing more detailed and focused codes whilst comparing codes across data and datasets. In addition to the a priori constructs, we developed two hierarchical codes and a code for the phenomenon under study, *anti-social behaviour*. The hierarchical codes include: *Drivers of joint working* (sub-themes: *recognised needs/problems* and *processes and responsibilities*) and *Foundations of joint working* (sub-themes: *understanding roles and responsibilities*, *valuing others’ contributions* and *willingness to work towards shared goals and outcomes*). The code for the phenomenon under study, *anti-social behaviour*, encompasses the range of perceptions and interpretations of anti-social behaviour by the participants (Bazeley, 2013). We also added detail to our scenarios. Memos were written throughout the process to support the development of relational analysis (Bazeley, 2013).

Table 3: *about here*

Issues around rigour and credibility (Lincoln & Guba, 1985) were addressed by discussing the analysis and interpretation of the data within the research team, a group of service users and carers, and the Project Reference Group. NVivo 10 allowed us to record a clear and transparent audit trail.

Findings

We identified four main themes: the *continuum of joint working*, the phenomenon of *anti-social behaviour*, the *drivers of joint working* and the *foundations for joint working*. We found a *continuum of joint working* that matched that posited by Hudson and colleagues (1997). Understanding other professionals' contributions, valuing these and working towards shared goals were identified as the foundations for joint working. Joint working practices were influenced by organisational context and framed by policy and funding demands (*drivers of joint working*).

The Continuum of Joint Working

Our findings mapped on to the stages (*sub-themes*) described as *encounter*, *communication* and *collaboration* (Hudson *et al.* 1997; see Table 3). We did not find any examples of the extremes – isolation or integration, and our data suggested that ad hoc encounters and communication were more common than collaboration.

In the current study, ad hoc encounters were more likely to be a response to a person's specific behaviours experienced as distressing, alarming or harassing (such as repeat callers) by the community or professionals than a person with mental ill health being targeted by others. These encounters tended to focus on short-term problem solving. Getting organisations involved and information sharing was often difficult.

We found frequent information sharing about individuals whose needs crossed organisational boundaries (described as communication by Hudson *et al.*, 1997). The focus was on prevention and putting longer-term plans into place rather than specific behaviours.

At the further end of the continuum of joint working (collaboration), professionals had developed a shared recognition that complex needs demanded input from a range of organisations. Relationships had developed over time with awareness of roles and responsibilities and the development of trust.

The Relationship between Anti-Social Behaviour and Mental Health

There was considerable variation in professionals’ perceptions about the nature of anti-social behaviour and their roles and responsibilities in responding to it:

I guess it [anti-social behaviour] would be a broad spectrum, it would be behaviour that was to be deemed unacceptable within a set of norms and that would change depending on where you lived. (ASB_I.6, Mental Health)

Behaviour was interpreted according to context. For example, self-harm was described as anti-social behaviour if another person found it distressing. This variation in interpretation can be a major barrier to joint working. Findings from the police cases showed no consistent recording of anti-social behaviour across and even within police forces. This was confirmed by police officers: “We can all go to exactly the same job and it can all be dealt with differently, so it’s...” (ASB_FG.65, Police).

Professionals may not be aware whether a person with mental ill health is being considered to be a victim or perpetrator of anti-social behaviour (or indeed both) by the police. Some professionals may reject this type of classification as reductionist - convenient black and white categories which might obfuscate poor social skills or distress:

A lot of our clients do behave in a way that is different to the norm, we wouldn’t class that as antisocial behaviour, we would probably be inclined to think to ourselves, “Oh, that’s probably symptomatic of their mental illness” (ASB_I.15, Third Sector Organisation).

Police officers pointed out that although behaviour may be logged as anti-social, this categorisation is not necessarily shared with the person concerned.

One of the challenges in developing joint working practices was the complexity of the issues presented. Findings from all data sources indicated that people who required a large input of police time because of anti-social behaviour tended to have enduring mental health problems and complex needs (such as experience of trauma, substance use, homelessness and/or experiences of abuse and violence). For example:

Interviewer: And from your work on antisocial behaviour cases could many of the people involved be classed as vulnerable and have a sort of mental health issue and substance misuse issues?

Officer 1: A lot of mine do. (ASB_FG.53, Police)

Officer 2: All the time. (ASB_FG.55, Police)

People were likely to have been in contact with a number of agencies over time and had fluctuating levels of engagement with organisations.

What drives Joint Working?

For people and organisations to engage in joint working, there has to be a driver such as a recognised need or problem, a specific project, or ideological or ethical motivations (Carnwell & Carson, 2009). The main drivers for joint working (*subthemes: recognised needs/problems and processes and responsibilities*) were legal requirements and obligations to protect the most vulnerable and at risk. This included statutory arrangements for: the protection of vulnerable adults; people experiencing domestic violence; and for managing sexual and violent offenders. Feedback from staff, and in particular senior and management, indicated that organisations find it hard to neglect their responsibilities as expectations of roles and processes are clearly documented in policy and guidance. These frameworks facilitate joint working:

MAPPA [Multi-Agency Public Protection Arrangements, statutory arrangement for managing sexual and violent offenders] has made that a lot easier [...] the police will let us know if she's rung up with any self-harm, so that we can update our risk assessments and our management plans, etc., [...] that's worked really well. And again that's – having a really good relationship with the police and [...] where there's big risks, and that's worked really well. (ASB_I.14, Mental Health)

There were also a number of forums dealing with people who persistently behave in an anti-social way or are victimised by repeated anti-social behaviour. These forums were created in response to police policy and guidance and included police, housing and local authorities but rarely mental health services. Other examples were local groups formed as a response to specific challenges (for example, people with mental ill health at high risk of becoming homeless). Partnerships were in place to deliver local mental health strategies based on policy guidance, typically involving police, local authorities, health and social care and third sector organisation. However, few participants mentioned them, suggesting a lack of awareness or impact.

Although the forums had shared goals, not all had the authority to get professionals to follow through with actions. Practical arrangements have to be made:

You have multiagency meetings for the protection of vulnerable adults, people have to - you know, that's the whole point of having those meetings, they have to complete those tasks that are put out to them. Whereas sometimes you could go to the problem solving group and one agency is supposed to do something about a problem and they don't do it or they've - you know, for whatever reason that might be if they've been too busy or they've just forgotten, that can cause problems. (ASB_I.21, Police)

We found no formal links between forums. This meant that a person might be reviewed in different forums, without members of the forums being aware of it. Where

communication existed, it depended upon individual professionals and relationships they had established.

The Foundations for Joint Working

There were a number of building blocks (sub-themes), which needed to be in place to enable joint working to develop. This included an *understanding of roles and responsibilities*, *valuing other professionals' contributions* and a *willingness to work towards shared goals* and outcomes.

Understanding of each others' roles and responsibilities. Although essential for joint working, this was often missing:

I think it could be useful for the police, and – and for us as well to really understand what each, team does, because I think that is still limited. (ASB_I.13, Mental Health)

A lack of understanding can lead to inter-organisational conflict:

And it's really hard, I think sometimes, because we sometimes get some very angry people [police] on the phone saying "Well, we can't do that, you're asking us to do something that would be a breach of duty for us. You know, I don't care if they've [patient] signed a care plan, it's not our care plan and we don't know what to do."

And you are stuck in a really challenging situation then. (ASB_I.22, Mental Health)

This highlights the underlying tensions and uncertainties about the role of the police regarding mental health issues. Responses about the optimal role of the police in mental health were inconsistent across and within professions. Some participants felt that the police should be purely dealing with criminal matters whereas others felt that the police should fulfil safeguarding and public health duties: "I suppose ours is a safeguarding role as well isn't it?" (ASB_I.21, Police).

Being aware of and valuing other professionals' contributions. Some of the participants did not see others as important partners and there seemed to be a lack of

enthusiasm for creating relationships that could support the development of joined working practices with shared goals. This was often accompanied by stereotypical and/or negative perceptions:

I could probably speak for most police officers in that our, practical, um, experience of social services is really, really poor. [...] We quite often get what we call hit and runs, so on a Friday at half four they'll phone up reporting a problem [...]. (ASB_I.9, Police)

Some mental health professionals felt that the police did not understand recovery and wanted to resort to control too readily. Police officers were perceived to interpret any signs of distress as mental health problems and call for assessments unnecessarily:

Sometimes as well is that they tell individuals, you need a service from the mental health team, and you know they wouldn't reach our criteria for a service. (ASB_I.37, Mental Health Social Worker)

Reluctance to engage in joint working was associated with a strict role adherence and a concern to protect organisational boundaries:

We've had what we perceive as a mission creep into areas that should be the health service. (ASB_I.36 Police)

Some mental health staff appreciated the challenges the police face:

The police are the first port of call and they go out there, they're not trained [...] I think quite often the police are left feeling isolated, they don't know who to contact. (ASB_FG.43, Mental Health)

Willingness to work towards shared goals and outcomes. There were challenges related to “*different goals, different agendas*” (ASB_I.29 Local Authority). Participants suggested that some people focused on their organisational goals and criteria to the detriment of the person with mental ill health. This can lead to serious inter-organisational tension.

Findings from all data suggested a number of issues: the right of the individual versus the community; managing risk versus promoting recovery; and planning management of the person in the community to prevent crisis and relapse versus ad hoc crisis intervention. Crisis response and a focus on service tasks were seen as highly problematic:

You know, we're struggling for appointments for people who are - are low and medium risk, so I - I get there has to be some kind of cut off, but it's just a shame sometimes when you can see the way things are going and you know as soon as that person triggers a high risk, they get everything they need. Well, you know, wouldn't it be nice if we could give them that a few months before and save everyone going through the pain. (ASB_I.9, Police)

Inability to record the need for, or agree shared outcomes can have serious consequences for the individual. Examples from all data sources include: homelessness, going into a mental health crisis, compulsory admission, self-harm or suicide.

Reluctance to develop joint working was set in the context of a tightening of criteria as a way of coping with limited resources:

You know, there's sixteen thousand less officers in the country than there were four years ago, so we are saying "no, that's your [mental health team] role, you do that". (ASB_I.35, Police)

Lack of funding can lead to organisations looking to focus on their specific service tasks rather than the needs of individuals:

They [Health Board] tend to stick religiously to the way that they've got to function [...] it's so, "no we can't touch that, it doesn't tick the box". Well, they're individuals and it's not going to be a tick box exercise. It's not like going shopping. So there just needs to be that flexibility (ASB_I.27 Local, Authority)

Discussion

This research has explored joint working practices between mental health, social and criminal justice organisations with respect to anti-social behaviour. Joint working enables organisations to share expertise in order to provide comprehensive support services, but most importantly to make a difference to people’s lives.

We found a continuum of joint working practices influenced by a number of factors in line with previous research (Hudson *et al.*, 1997; Leutz, 1999, 2005). For joint working to take place, it has to move from a marginal to a mainstream position in an organisation (Hudson *et al.*, 1997). The tendency to focus on task-based service provision and hardening of organisational boundaries may be linked to the challenges that people with complex needs pose. Their behaviour and problems touch on the remit of several organisations without being a core task for anyone. These complex needs are hard to resolve and require long-term co-ordinated management. Funding cuts and increased work pressures create a difficult context to achieve this. Rigid service criteria disregard the inability of any single organisation to provide for the totality of complex needs (Cameron, Lart, Bostock & Coomber, 2014; Lamb, Winberger & DeCeur, 2002).

Our findings suggest that working practices between the police, mental health, social care and third sector organisations are in the earlier stages of joint working. Joint working is not central to mainstream activities. There was a lack of awareness and understanding of other professionals’ roles and responsibilities. Communication was challenging. Participating organisations did not generally engage in partnership working in terms of shared commitments, rights and obligations (Carnwell & Carson, 2009) and some lacked the basics such as established communication channels and mutual understanding (Leutz, 1999). Organisational commitment is necessary to create relationships with a shared vision but this is not firmly in place.

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3 Organisations need to have open discussions about the purpose and level of
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5 partnership working they are aiming for, and agreement on practical and governance
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7 arrangements. In keeping with the literature, we found that partners do not necessarily share
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9 the same level of commitment and are likely to be motivated by different agendas and
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11 priorities (Hudson, 2006; Leutz, 2005). Joint working was mainly driven by policies that
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13 direct activities or place specific legal obligations (for example, for vulnerable persons),
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15 generally relating to high risk. Differences in organisational culture and values can lead to
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17 clashes over legitimacy and accountability (Hudson *et al.*, 1997, Skelcher, 1998).
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21 There can be tensions between the interests of an individual and the community, and
22
23 goals must be negotiated where there are disagreements about whether behaviour is anti-
24
25 social or a sign of mental ill health. We argue that this must be understood with due regard to
26
27 the tension and fragmentation between mental health and criminal justice policies. Anti-social
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29 behaviour, which is subjective and context-specific, underscores the challenges posed by
30
31 differences in judgements, perceptions and practices between professional groups. The range
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33 of stakeholders involved leads to different conceptualisations of the nature of the problem,
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35 and what constitutes best practice and care. In other words, challenges around joint working
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37 are intensified. Any behaviour that is outside of social norm could be labelled as anti-social
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39 and thus lead to social exclusion and the sphere of activity of anti-social behaviour is more
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41 likely to include vulnerable groups (Manders, 2009; Millie, 2009).
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45 The present study is relevant beyond the UK as it raises issues concerning our
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47 understanding and interpretation of the relationship between criminal justice and mental
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49 health care, in particular the role of the police as first line responders. In some countries,
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51 notably the United States, there is a call for a cultural shift in police work towards
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53 guardianship (Rahr & Rice, 2015) or even to locate police encounters with people with
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55 mental ill health in a public health frame (Wood & Watson, 2016). Public tolerance and the
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3 use of public spaces are common concerns across Europe and the USA (ADT Europe, 2006;
4 Rand Europe, 2006). However, there has been criticism of the merging of criminal justice and
5 mental health policy, which is interpreted as the policing, control and regulation of people
6 with mental health problems (Boyd & Kerr 2016; Wood, Swanson, Burris & Robertson,
7 2011).

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14 There are policy and strategic developments in the UK, which may create further
15 tensions, but also provide opportunities and directives for the development of joint working.
16 For example, the Mental Health Crisis Care Concordats in England and in Wales emphasise
17 partnership working to support people in mental health crisis. This includes planning for
18 recovery and staying well. Signatories include health and social services and the police. An
19 early evaluation of the Concordat in England has found constructive developments in
20 initiating and sustaining joint working with positive outcomes for people with mental ill
21 health (Gibson, Hamilton & James, 2016). The Policing and Crime Bill presented to the
22 House of Commons on February 2016 restricts the use of police cells as places of safety. This
23 relies on joint working arrangements to be in place to support people in mental health crisis.
24 Despite rising demands and spending reductions, a range of functions including
25 commissioning and provisioning, and commitment and communication at strategic and
26 operational level, must be developed to keep a focus on the person in the middle (Rummary,
27 2010).

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44 **Limitations**

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46 The following limitations should be kept in mind when considering our findings. The
47 quality and depth of the police data was variable which made it difficult to draw firm
48 conclusions about details of joint working practices. Examining a particular police case from
49 the perspective of multiple services would have provided more detail but this was not
50 possible owing to the agreed data sharing information protocols with the police forces.
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However, together with data from interviews and focus groups, our data provided an intriguing insight into joint working practices and challenges.

There were a few issues in relation to recruitment. Resource constraints limited the subsamples from managerial/senior level and operational staff in both sites and a smaller pool of staff in our rural study area may have limited this sample.

The present study relied on qualitative data and as such, there may be questions about the interpretation and transferability of the findings. We have taken a number of steps to address these issues. These include the data integration approach used by Moran-Ellis and colleagues (2006), on-going discussions about data interpretation amongst research team members, the Project Reference Group and a group of service user and carers.

Future Research and Implications of the Findings

Future research should collect quantitative as well as qualitative data to provide a more comprehensive picture. A larger sample covering a number of geographical areas would enhance the strength and validity of the findings. The current research study focused on mental health and social care services providing secondary care. Future research should also include primary care staff as they have an increasingly important role to play in the support of people with mental ill health (Whitley *et al.*, 2015).

The findings of the current research have implications for health and social care organisations and the police. They highlight the need to reflect on current joint working practices and to focus on the health and welfare needs of individuals, rather than task completion and professional boundaries. Thinking about joint working in terms of a continuum would allow services to reflect on their current policies and practices. In particular whether these are optimal and support meaningful involvement of service users and carers. The findings show continuing tensions and contradictions between the mental health and criminal justice system and the urgent need to raise awareness of the challenges.

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Table 1. Details of data collection in phase 1 and 2

Phase 1
<ul style="list-style-type: none">- An information sharing protocol was agreed between each police force and the research team- Routinely collected anonymised narrative anti-social behaviour data was shared by two police forces- This encompassed 30 cases from each police force, with narratives spanning variable periods between August 2011 and December 2014- Selection criteria:<ul style="list-style-type: none">• Flagged on the police system as involving mental health issues,• Presence of <i>repeated</i> anti-social behaviour,• Tagged as anti-social ‘personal’, which refers to an individual exhibiting or being targeted by anti-social behaviour
Phase 2
<ul style="list-style-type: none">- Conducted face-to face interviews (n = 37) and two focus groups with seven and nine participants respectively, using a topic guide (N = 55)- Data collection between January and August 2016- The topic guide was developed based on the literature, analysis of data from Phase 1 and in consultation with the Project Reference Group- Purposive sample: Representatives from statutory services including Mental Health Services, Social Care Services and the Police Force, and Third sector organisations delivering mental health care and policing in the study areas

Table 2. Participants in semi-structured interviews and focus groups

Type of job	No. of Participants		Total
	Site A	Site B	
Mental Health Services ^a			
Manager/Senior staff	2	2	4
Community Mental Health Team (CMHT) staff ^b	10	4	14
Police and probation			
Manager/Senior staff	1	2	3
Officers	8	7	15
Local Authorities ^c			
Manager/Senior staff	2	2	4
Practitioners	1		1
Third sector organisations			
Manager/Senior staff	5	2	7
Case worker	5	2	7
Total	34	21	55

^a Includes representatives from three CMHTs in each site. ^b Includes two mental health social workers.

^c Professionals working with anti-social behaviour, vulnerable adults and/or housing.

Table 3. Descriptions and examples of joint working themes

Themes	Characteristics/Description		Examples
	Continuum of Collaboration ^a	Our Data	
Encounters			
	<ul style="list-style-type: none">• Some ad hoc contacts• Loose networks• Divergent organisational goals• Stereotyping and perceived rivalry	<ul style="list-style-type: none">• Focus on short-term problem solving• Lack of understanding of professional roles and responsibilities• Difficulty getting organisations involved• Challenges information sharing• Discussion about whose problem it is	<p>Quotes</p> <p><i>I think it would be very valuable for the police to come and [...] see how things operate within the mental health field. Equally, I think it would be very useful for mental health professionals to see the work of the police as well.</i> (ASB_I 1.13 Mental Health)</p> <p><i>It very much seems to be a mind-set of mental health services in [place], "we only work Monday to Friday, nine to five" And inevitably people who are suffering from mental health problems, inevitably – it's out of hours [...] So, it's frustrating because we always end up as the sort of response because we are 24/7 and we're the only agency to go.</i> (ASB_I 1.20 Police)</p> <p>Police case notes:</p> <ul style="list-style-type: none">• Repeatedly contacting an agency, asking for assistance and help• Several references to following-up referrals to social and mental health services which have not resulted in any action• Reference to not being kept informed by Community Mental Health Teams (CMHTs) and concerns not being taken seriously• Multi-agency meetings cancelled
Communication			
	<ul style="list-style-type: none">• Joint working but marginal to organisational goals• Information sharing for individuals whose needs cross boundaries• Some joint training	<ul style="list-style-type: none">• Starting to consider longer-term plans for people• Developing understanding of other professionals' roles and responsibility and what others can	<p>Quotes</p> <p><i>I mean we have a good relationship with X police, so they will attend complex case meetings that we as a team facilitate, so that would be for anybody who has mental health and substance use.</i> (ASB_I 1.56 Third Sector)</p> <p><i>We do have an information sharing protocol and it's on a need to know really in terms of risk. So obviously if we felt that an individual was at risk to his or herself or to others then we would share that information with the police if that was relevant.</i> (ASB_I 1.37 Mental Health)</p>

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|--|--|---|
| <ul style="list-style-type: none"> • Nominated person for liaison • Expect reciprocity | <ul style="list-style-type: none"> • contribute • Sharing information if a person is perceived to be at risk • Recognition that it may be a shared problem • Nominated link person | <p>Police case notes:</p> <ul style="list-style-type: none"> • Mental health liaison police officer involved and up-dating the notes • Notes about convening case conferences to address specific issues • Example of a CMHT contacting police to highlight that a vulnerable person may become a victim of anti-social behaviour, plans put into place to address potential issues • Notes about information shared • Example of police officers and case workers from a third sector organisation attending a care planning meeting led by the CMHT to discuss care provision and support. |
|--|--|---|

Collaboration

- | | | |
|---|---|--|
| <ul style="list-style-type: none"> • Joint working part of mainstream activities • Trust and respect in partners • Highly connected networks • Low expectation of reciprocity | <ul style="list-style-type: none"> • Focus on prevention and longer-term planning as part of organisational working • Understanding of others' roles and responsibility and valuing of contributions • Agreed information sharing protocol and mechanisms • Tends to have developed over time • Often involves a champion • A certain level of trust has been established | <p>Quotes</p> <p><i>It's networking, we're all sat round the table and then the next time we have somebody and we've got a question about them we can pick up the phone and ask. [...] there's certain people in every team that you can work well with, some people you just go that extra mile for you at times and you do the same back.</i> (ASB_I 1.56 Third Sector)</p> <p><i>The change happened slowly, starting off with us ringing the CMHT "I just want to make you aware that..." They recognised the value of this and slowly started to exchange information. So they now call and say "Put this about Y on your log. He presented to us this way today and he might call you over the week-end. But treat this as a manifestation of his illness rather than a crime".</i> (ASB_I 1.25 Police)</p> <p>Police case notes:</p> <ul style="list-style-type: none"> • Reference to regular multi-agency meetings of nominated staff about people who are perceived to be vulnerable or have been highlighted by other agencies as needing support; longer-term support planning and solutions noted • Reference to contacting a particular person/organisations in different cases and documenting positive partnership working • Examples of swift resolution of cases with clear information about what other organisations have done and how it will be monitored • References to agreed processes and/or policies |
|---|---|--|

^aDescription of themes based on the continuum of collaboration developed by Hudson *et. al* (1997) as cited in Carnwell and Carson (2009)

Box 1: Typical scenario

David is in his forties and lives in a housing association flat. He has a diagnosed mental health illness and is under the care of a Community Psychiatric Nurse (CPN). David does not always take his medication.

Recently, David has been getting in touch with the police at an increasing rate. He reported several times that his neighbours are very noisy and disturb his sleep. He has also reported that the neighbour’s children laugh when they see him, call him names and run after him. The police have talked to the neighbours but David thinks this has made things worse.

David feels threatened and insecure and he is starting to worry about going out. When he meets other people from the building he does not talk to them and sometimes tries to hide. He also seems to take less care of himself and some of the other tenants have mentioned this to the housing association. The police try and deal with the situation numerous times and have been in touch with the housing association and the Community Mental Health Team (CMHT). The CMHT tells the police that they cannot share any information about David due to patient confidentiality but that he is fine. David’s phone calls to the police increase. One of the other tenants calls an ambulance for David a couple of weeks later and he is sectioned.

Box 1: Example scenario

For Peer Review